A comprehensive treatment service must include developmental, systemic and collaborative components

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In the absence of a strong evidence base for treatment of eating disorders, it is inevitable that there will be disagreement about what is the most appropriate treatment service. Much of K. Halmi's overview of what constitutes such a service is helpful and uncontroversial. In this commentary, I will focus on what I believe to have been neglected, insufficiently acknowledged or out of keeping with contemporary views or practice.

The first omission is that of a developmental focus. The peak age of onset of eating disorders is between 14 and 18, a time of considerable physical and psychological maturation. Increasingly prepubertal children are developing these disorders. The potential for physical decompensation is far greater in childhood and adolescence than in adults. Particular attention needs to be paid to bone growth, both linear and density, and to reproductive organ status, all of which are threatened by inadequate nutrition. Body mass index (BMI) per se is unhelpful, as it needs to be monitored according to age, using BMI centiles for age (1). Stipulating a specific BMI for under 18s, upon which decisions are made, is misleading.

From a psychological perspective, developmental issues pay a vital part in the pathogenesis and maintenance of eating disorders and subsequently need to be central to assessment and treatment. Linked to this is the importance of a systemic perspective. Children and adolescents live with their families, attend school and are intensely involved with their peer group. The family history is far less important than parental management of the illness and the parents should *always* be included in both the treatment planning and its delivery. Indeed, family-based approaches to treatment for adolescent anorexia nervosa have a good evidence base and are central to the National Institute for Clinical Excellence (NICE) guidelines for its management (2).

The multi-disciplinary team is, as Halmi suggests, an essential part of any treatment programme. However, Halmi makes no mention of nurses, who are central to the treatment on in-patient units and are often involved in day-care, out-patient clinics and home-based treatments. Her description of the ward milieu and physical structure of an in-patient unit emphasises "compliance", with monitoring, controlling and restricting patient activities. Patient autonomy, privacy, comfort or rights receive virtually no attention. And there is no mention of some essential components of treatment, be that on an in- or out-patient basis: a) building a therapeutic alliance; b) skilled communication; c) empathic exploration of the patient's anxieties, concerns and cognitions; d) enhancing motivation – the unmotivated patient is far more likely to drop out of treatment (3).

Halmi suggests that a cognitive behavioural approach within an in-patient unit is best. However, while there is good evidence for the value of cognitive behavioural therapy for bulimia nervosa, there is no evidence that it is of any value for patients with anorexia nervosa who are of low weight, i.e. the vast majority of patients admitted to hospital with an eating disorder.

Turning to medical management, I disagree with Halmi's suggestion that in-patients should be weighed daily. Such an excessive preoccupation with weight mirrors that of our patients and simply reinforces it (1). In any event, weight is not a valid indicator of physical well-being, for numerous reasons: a) weight varies by as much as 1.5 kg within any 24 hour period; b) the process of weighing is totally unreliable, given the fallibility of scales; c) weight can be easily falsified and many patients will do so to escape from a coercive treatment regimen; in contrast, some children and adolescents will avoid weight gain to ensure they are not discharged home to an abusive environment; d) what constitutes

a satisfactory BMI for one person may be too high or too low for others, given the enormous variation in healthy BMI across the population.

Weight/BMI should be but one measure of physical well-being and its unreliability acknowledged and allowed for. Weight might be measured on a regular basis, but it should never be the sole determinant of management decisions, and most certainly daily weighing should be avoided. If there is considerable anxiety about a patient's physical state, then vital signs and electrolyte status will provide far more valid and useful information.

Halmi makes no reference to the exciting advances in our understanding of the neuroscience of eating disorders and their clinical applicability (4-6). A primary neurobiological basis for eating disorders is almost certain, given the neurotransmitter disturbances (7,8), the consistent and persisting abnormalities in very specific domains of neuropsychological functioning (9-13), and the specific, localized and persisting abnormalities on neuroimaging (5,14,15). The clinical implications are profound, pointing to the need for treatments targeted at the underlying neurobiological substrate. The use of cognitive remediation therapy is producing some impressive results, even in those with very long-standing illness, with symptomatic improvement in both symptoms and cognitive deficits (11,16).

Finally, Halmi makes no mention of the importance of including high dependency and secure facilities for those whose eating disorders require far more intensive nursing than usual or whose behaviour is life threatening. The availability of step-down facilities, from secure/high dependency units, via specialized in-patient units and day care, to out-patient clinics and domiciliary care would make for a far more comprehensive service.

A truly comprehensive service would need to have a full range of specialists, including nurses and therapists trained in motivational enhancement therapy and cognitive remediation therapy. The service would need to be clearly subdivided into two sections, one for children and adolescents, with an emphasis on developmental and systemic issues, and the other for adults. The ethos of this comprehensive service needs to be grounded, not in compliance, coercion and monitoring, but in the therapeutic alliance.

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